42 CFR 447.253 (b) (1) (iii) (B)---Nursing Care Waivers

The Indiana Family & Social Services Administration through its Medicaid rate setting criteria at 470 IAC 5-4.1, has developed methods and standards in determining Medicaid payment amounts to nursing facilities that take into account potential reductions in facility costs associated with granting of waivers to provide licensed nurses on a 24 hour basis, and incorporates the final impact of those waivers into appropriate rate setting adjustments for long term care facilities.

42 CFR 447.253 (b) (1) (iii) (C)---Public Information

The State Medicaid agency has established procedures under which the data and methodology used in establishing payment rates to nursing facilities can be and is made available to the public. Such methods include the generation of provider profiles on each Medicaid rate case calculated, the collection, retention and systematic summarization of provider cost report data through an automated Long Term Care Information System, the proper publication of rate setting criteria rules and the making available of all of the above cited information to interested parties through various means.

42 CFR 447.253 (b) (2)---Upper limits

The State of Indiana, through the IFSSA, has determined that the estimated average proposed Medicaid payment rate calculated with the reimbursement rules promulgated at 470 IAC 5-4.1 is reasonably expected to pay no more in the aggregate for long term care facility services than the amount the Department reasonably estimates would be paid for those services under payment limits referred to in 42 CFR 447.272 (Medicare principles of reimbursement).

42 CFR 447.272 (b)---Upper Limits (State Operated Facilities)

The State of Indiana, through this Department, issues reimbursement rates to State operated facilities and estimates that the average proposed Medicaid payment rate to each group of State operated facilities, which could include hospitals, nursing facilities, and nursing facilities for the mentally retarded, is reasonably expected to pay no more in the aggregate for long term care facility services than the Department reasonably estimates would be paid for services under the Medicare principles of reimbursement.

42 CFR 447.253 (d)--Asset Valuation, Change in ownership of NFs and ICFs/MR

In conformance with 42 USC 1396 (a) (13) (C) (i) and (ii) otherwise known as 1902 (a) (13) (C) of the Act, the Office computes payment rates that include a capital return factor that can be expected not to increase Medicaid payment rates in the aggregate, simply because of the change in ownership, more than Medicare payments would yield using sections 413.130, 413.134, 413.153 and 413.157. This capital return factor limit which applies to ownership transfers from 7-18-84 through 10-1-85, reimburses for depreciation, interest on capital indebtedness, return on equity capital, and takes into account acquisition costs which were previously reimbursed to prior owners as well as allowing for the recapture of depreciation.

For ownership transfers on or after 10-1-85, The State of Indiana through this Office, has adopted regulations which mirror the language at 1902 (a) (13) (C) of the Act, limiting the capital return factor component of Indiana long term care facility rates to those limits established by the above cited legislation and as stated in the Code of Federal regulations at 447.253 (d) (2) (i) or (ii), whichever is applicable.

42 CFR 447.253 (e)---Provider Appeals

The State of Indiana, through the IFSSA, provides for an administrative review and appeal procedure whereby long term care providers may submit additional evidence and request prompt administrative review of payment rates, as evidenced by 470 IAC 5-4.1-27.

42 CFR 447.253 (f)---Uniform Cost Reporting

The State of Indiana, through the IFSSA, requires providers of long term care facility services to submit uniform cost reports of IFSSA design, as evidenced by 470 IAC 5-4.1-2 (k), 5-4.1-4, and 5-4.1-5.

42 CFR 447.253 (g)---Audit Requirements

The State of Indiana, through the IFSSA, provides for periodic field audits of long term care facility financial and statistical records as evidenced by 470 IAC 5-4.1-1 (c), 470 IAC 5-4.1-2 (j) and 470 IAC 5-4.1-3.

42 CFR 447.253 (h)---Public Notice

The State of Indiana, through the Office, complies with all public notice requirements as set forth in the CFR at 447.205 This amendment contains "no change" in methods or standards for setting payment rates thus there is no public notice requirement. Each NF has received an individual rate notice conveying its specific rate.

42 CFR 447.253 (i)---Rates Paid

The State of Indiana, through this Office, utilizes long term care facility reimbursement rates which have been determined in accordance with methods and standards which are specified in an approved State Plan. The reimbursement rates have been computed in accordance with the rules at 470 IAC 5-4.1 et. seq. (1988 ed.) as found at attachment 4.19D of the Indiana approved State Plan.

OBRA 1987 Assurance

The State of Indiana, through this Department, has submitted State Plan amendment 90-8, effective 10-1-90, said amendment having been approved by HCFA, which takes into account the costs of nursing facility compliance with the requirements of section 1919 (b)--- (other than paragraph 3 F thereof (c) and (d)). These identified costs are being converted into average proposed payment rate adjustments to nursing facilities as detailed in the State Plan and as required by OBRA '87. The attached amendment provides more specific detail on the OBRA rate increase effective 10-1-93.

OBRA 1990 Assurance

The State of Indiana, through this Department, and through this document, provides the assurance that the Department has adopted reimbursement criteria that takes into account the costs, including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits, as required by Section 1902(a)(13)(A)/42 U.S.C. 1396a(a)(13)(A), and as specified in OBRA 1990, Public Law 101-508.

ASSURANCES END

OBRA '87 AND '90 MEDICAID NF COST RECOGNITION & RATE INCREASE
FOR FEDERAL FISCAL YEAR 1995 EFFECTIVE 10-1-94

The Indiana Office of Medicaid Policy & Planning annually computes facility specific rates for Medicaid enrolled nursing facilities using a prospective methodology that requires NFs to submit annual reports of historical costs for a projected rate year.

Based on information contained in the Office's Long Term Care Information System gathered from all Medicaid enrolled nursing facility provider's historical cost reports as of June 1994, the following information is provided indicating the OBRA rate increase for federal fiscal year 1995. Because the effective date for this amendment will be 10-1-94, the actual statewide average Medicaid rate effective 9-30-94 is used to provide the base rate for the increase information. The rate is broken down into two components, the rate with OBRA costs included prior to 10-1-94, the OBRA increase on 10-1-94 and the final nursing facility single statewide average rate with OBRA cost increases on 10-1-94. Adjustments are required by Section 4211(b) of OBRA 1987 and 4801(e) of OBRA 1990.

The rate information specific to OBRA is determined as follows. Medicaid NF rates are calculated in conformity with the provisions outlined in this plan at pages 1 through 68 B of attachment 4.19D. These pages are incorporated by reference to provide the basic rate setting methodology including prior OBRA increases. In addition to these provisions, to segregate and arrive at OBRA specific cost increases allowable for rate recognition, Medicaid has compared NF costs for historical years prior to and after 10-1-93, documented and categorized the cost increases, reduced the cost increases by the GNP/IPD and HCFA/SNF inflators for the period in order to reduce cost increases to true operation increases, identified those costs that are attributable to OBRA requirements that necessitated additional expenditures by NFs after 10-1-90, and converted those costs to a per-patient-day increase as reflected by the following rate information.

THE EFFECTIVE DATE FOR INFORMATION ON THIS CHART IS 10-1-94

OBRA RATE YEAR	SINGLE STATEWIDE AVERAGE NF RATE EFFECTIVE 10-01-94 WITH PRIOR OBRA INCREASES INCLUDED	10-1-94 OBRA INCREASE	SINGLE STATEWIDE AVERAGE NF RATE WITH OBRA INCREASE 10-1-94
1994/95	$71.69	.03 ppd	$71.72 +(.0004)

The OBRA rate increase of .03 ppd. represents the increase of cost recognition for the following listed OBRA '87 requirements. The prior .76 ppd. when added to this .03 increase represent a total increase of .79 ppd. since 10-1-90 for OBRA cost recognition.

COST RECOGNITION CATEGORIES

1. Resident's Rights-Transfer and Discharge Requirements 42 CFR 483.12(a)(5)(ii), consisting primarily of requirements to implement a resident appeal procedure associated with transfer and discharge of residents.

2. Other Staffing Requirements-Social Service Qualifications 42 CFR 483.15(g)(2)(ii) and 483.15(g)(4), requirement for and minimum qualification standards of a social worker for facilities with more than 120 beds.

3. Resident Assessment-42 CFR 483.20, requirement regarding frequency, timing and accuracy of resident assessments.

4. Plans For Care-42 CFR 483.20(d), requiring changes in timing and content of the resident care plan.

5. Resident Assessment Discharge Summary-42 CFR 483.20(e)(3), additional requirements to develop a discharge plan.

6. Nurse Staffing Requirements-42 CFR 483.30, requiring increase in nurse staffing resources in Indiana NFs with fewer than 40 beds to reach one full time equivalent RN.

7. Other Staffing Requirements-Dental Services 42 CFR 483.55, requiring increased responsibility placed on NFs to ensure resident's receipt of needed dental care.

8. Other-Inflation Applied Against 10-1-90 Cost Recognition

CATEGORY	COST RECOGNITION	PPD RATE INCREASE	PERCENT OF TOTAL INCREASE
1	$ 48,318	.0053	.7
2	$ 4,426,695	.4846	62.0
3	$ 494,414	.0541	6.9
4	$ 491,066	.0537	6.9
5	$ 287,438	.0315	4.0
6	$ 362,403	.0475	5.0
7	$ 780,807	.0855	10.9
8	$ 248,081	.0272	3.5
TOTALS	$ 7,139,222	.7894	99.9

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TITLE 405 FAMILY AND SOCIAL SERVICES ADMINISTRATION

LSA Document #94-59(F)

DIGEST

Adds 405 IAC 1-12 to establish reimbursement policies for services in a community residential facility for the developmentally disabled and a nonstate-operated intermediate care facility for the mentally retarded. Effective 30 days after filing with the secretary of state.

405 IAC 1-12

SECTION 2. 405 IAC 1-12 IS ADDED TO READ AS FOLLOWS:

Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled

405 IAC 1-12-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified intermediate care facilities for the mentally retarded (ICF/MR), with the exception of those facilities operated by the state, and community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 405 IAC 1-4. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish

effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process.

(e) Providers must pay interest on all overpayments. The interest charge shall not exceed the percentage set out in IC 24-4.6-1-101. The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1)*

405 IAC 1-12-2 **Definitions**

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing or resident care, room and board, supplies, and all ancillary services within a single, comprehensive amount.

(c) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(d) "Annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule which shall constitute a comprehensive basis of accounting.

(e) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be computed on a statewide basis for like levels of care, with the exception noted in this subsection, and shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1. If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred and forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.

(f) "Change of provider status" means a bona fide sale or capital lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.

(g) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(h) "CRF/DD" means a community residential facility for the developmentally disabled.

(i) "DDARS" means the Indiana division of disability, aging, and rehabilitative services.

(j) "Debt" means the lesser of the original loan balance at the time of acquisition and original balances

of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(k) "Desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(l) "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(m) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(n) "Forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(o) "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(p) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(q) "ICF/MR" means an intermediate care facility for the mentally retarded.

(r) "Like levels of care" means:

(1) care within the same level of licensure provided in a CRF/DD; or

(2) care provided in a nonstate-operated ICF/MR.

(s) "Office" means the Indiana office of Medicaid policy and planning.

(t) "Ordinary patient or resident related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

(u) "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.